DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Disability and Elder Services
DDE-2062 (Rev. 4-06)

STATE OF WISCONSIN
Bureau of Quality Assurance

FOR OFFICE USE ONLY
License No.
License Fee
Caregiver Background Fee
Effective Date

HOME HEALTH AGENCY OR HOSPICE LICENSE APPLICATION

TYPE OF AGENCY	TYPE OF APPLICATION
☐ Hospice ☐ Home Health Agency	☐ Initial ☐ Change of Ownership

Completion of this form is required by s. 50.49(10) Wis. Stats., for home health agencies and s. 50.93(10) for hospices. Failure to complete this form may result in non-issuance of a home health agency or hospice license. The personally identifiable information collected on this form will be used to determine licensure eligibility and for statistical information and for no other purpose.

HOME HEALTH AGENCIES ONLY Collection of the applicant's social security number (SSN) or federal employer identification number (FEIN) is required by s. 50.498(1) Wis. Stats. Failure to supply the number may result in denial of the application. The number will be disclosed only to the Department of Revenue for use in collection of tax delinquencies.

Questions about completion of this application may be directed to the Provider Regulation and Quality Improvement Section at 608-266-7782.

I. GENERAL INFORMATION

A. HOME HEALTH AGENCY / HOSPICE LOCATION

Name – Home Health Agency / Hospice Facility			Telephone Number
Street (physical) Address			Fax Number
Mailing Address			
City	County	State	Zip Code
E-mail Address			

B. CHANGE OF OWNERSHIP List the previous owner's name and license, Medicare and Medicaid numbers.

Name – Previous Owner		
License Number – Previous Number	Medicare Number – Previous Owner	Medicaid Number – Previous Owner

C. MULTIPLE / BRANCH LOCATION

Name – Home Health Agency / Hospice Facility			Telephone Number
Street (physical) Address			Fax Number
Mailing Address			
City	County	State	Zip Code
E-mail Address			

D. GEOGRAPHICAL AREA OF SERVICE (Counties Served)

Indicate, by county, the geographical service area.

1. Main Office

2. Branch / Multiple Location(s) If more than one location, attach additional pages.

E. SERVICES PROVIDED

1. TYPE OF HOSPICE SERVICES (Complete for HOSPICE application only.)

Check type of services provided. Provide information separately for EACH multiple location. Attach additional pages if necessary. Place a "1" if service will be provided directly and a "2" if the service will be provided by contracting with another provider of service. If services will be provided both directly and by contract, insert a "3".

Service	Main Office	Multiple Office	Service	Main Office	Multiple Office
Bereavement Services			Patient & Family Companion		
Dietary Services			Physical Therapy		
Homemaker Services			Respite		
Home Health / Hospice Aide Services			Speech / Language Pathology		
LPN services			Spiritual Counseling		
Medical Services			Social Services		
Nursing Services			Other (specify)		
Occupational Therapy					
Other Counseling Services					

2. TYPE OF HOME HEALTH SERVICES (Complete for HOME HEALTH AGENCY only.)

Check type of services provided. Provide information separately for EACH branch location. Attach additional pages if necessary. Place a "1" if service will be provided directly and a "2" if the service will be provided by contracting with another provider of service. If services will be provided both directly and by contract, insert a "3".

Service	Main Office	Branch Office	Service	Main Office	Branch Office
Appliance and Equipment Service			Occupational Therapy		
Home Health Aide			Personal Care Worker		
Homemaker / Companion Service			Pharmaceutical Services		
Laboratory Services			Physical Therapy		
Medical Social Work			Speech Therapy		
Nursing Care			Other (specify)		
Nutritional Guidance					

3. CONTRACTED SERVICES

Attach a list of all individuals, agencies and institutions with whom the agency has a contractual arrangement to provide patient care services. Include the names, addresses, types of services provided, e.g., PT, OT, SPT, the effective date of service and provider type, e.g., rehabilitation agency, home health agency, hospital, etc.

F. STAFFING

1. HOSPICES (Complete for HOSPICE application only.)

JOB TITLE	Full Time		Part-Time		Contract		Volunteers
	No. of Persons	Total No. of Hours Per Week	No. of Persons	Total No. of Hours Per Week	No. of Persons	Total No. of Hours	No. of Persons
Managing Employee / Admin.							
Physicians							
Registered Nurses							
LPNs / Lic. Voc. Nurses							
HH / Hospice Aides							
Physical Therapists							
Occupational Therapists							
Speech / Lang. Pathologists							
Bereavements							
Social Workers							
Counselors							
Dietary							
Other (specify)							
TOTAL							

Enter the number of hours in your official workweek. Enter a three digit number, e.g., 35.0, 37.5, etc

2. HOME HEALTH AGENCIES (Complete for HOME HEALTH AGENCY application only.)

JOB TITLE	Full Time		Part-Time		Contract	
	No. of Persons	Total No. of Hours Per Week	No. of Persons	Total No. of Hours Per Week	No. of Persons	Total No. of Hours
Administrator						
Companion						
Dietitian						
Homemaker						
Home Health Aides						
Medical Social Workers						
Personal Care Workers						
Physical Therapists						
Occupational Therapists						
Registered Nurses						
RN Supervisor						
Speech / Lang. Pathologists						
Other (specify)						
TOTAL						

Enter the number of hours in your official workweek. Enter a three digit number, e.g., 35.0, 37.5, etc

SECTION G IS TO BE COMPLETED BY HOSPICE APPLICANTS ONLY

G. TYPE OF HOSPICE AFFILIATION

☐ Hospital ☐ Home Health Agency ☐ Other, Specify _____

Name

Physical Address

City	State	Zip Code

Does your facility provide a place of residence for individuals with terminal illness? ☐ Yes ☐ No
If Yes, complete the following.

RESIDENTIAL FACILITY
(A permanent living arrangement.)

This is a free-standing facility. ☐ Yes ☐ No

This is a separate part of your structure. ☐ Yes ☐ No

Name (If different from the primary hospice.)

Address

City	County	State	Zip Code

Telephone Number	Fax Number	Number of Beds	Number of Beds in Each Room

List Room Numbers

SHORT TERM INPATIENT FACILITY
(A temporary arrangement for respite or symptom management care.)

Is respite or symptom management care service directly provided by the hospice in an inpatient setting? ☐ Yes ☐ No

Is respite or symptom management care a contracted service? ☐ Yes ☐ No

Name of Provider or Agency	Telephone Number

Address	Fax Number

City	County	State	Zip Code	No. of Beds

II. ADMINISTRATION

A. HOME HEALTH AGENCY / HOSPICE ADMINISTRATOR

Name - Administrator or Managing Employee			Effective Date

Title	Status ☐ Interim ☐ Acting ☐ Permanent

If the above individual holds a Wisconsin professional license, complete the following :

Type of License	Date Issued	Expiration Date

If the above individual holds a professional license in another state, complete the following:

Type of License	State	Date Issued	Expiration Date

Is the administrator or managing employee in charge of more than one agency? ☐ Yes ☐ No

If Yes, Name of Agency and City	Type of Health Care Provider

B. PERSON IN CHARGE IN ABSENCE OF HOME HEALTH / HOSPICE ADMINISTRATOR

Name	Effective Date

Title

If the above individual holds a Wisconsin professional license, complete the following :

Type of License	Date Issued	Expiration Date

If the above individual holds a professional license in another state, complete the following:

Type of License	State	Date Issued	Expiration Date

C. HOSPICE MEDICAL DIRECTOR (Complete for HOSPICE application only.)

Name - Medical Director	Effective Date

If the above individual holds a Wisconsin professional license, complete the following :

Type of License	Date Issued	Expiration Date

If the above individual holds a professional license in another state, complete the following:

Type of License	State	Date Issued	Expiration Date

Attach a resume, and a copy of the professional license, if applicable, for the administrator, managing employee and medical director, which includes their educational and work experience.

III. OWNERSHIP

A. APPLICANT / LICENSEE

Person(s) or business entity having the authority to direct the management or policies of the agency.

Name – Applicant	FEIN or SSN (HHA only)

Street (physical) Address

City	State	Zip Code

E-mail Address

County	Fax Number	Telephone Number

B. TYPE OF ORGANIZATION (Check type of ownership.)

GOVERNMENTAL	PROPRIETARY	VOLUNTARY NON-PROFIT
☐ City	☐ Sole Proprietary	☐ Corporation
☐ County	☐ Partnership	☐ Church
☐ State	☐ Corporation	☐ Association
☐ Federal	☐ Limited Liability Company	☐ Church / Corporation
☐ City / County	☐ Limited Liability Partnership	☐ Private Non-Profit
☐ Tribal	☐ Trust	☐ Limited Liability Company
		☐ Limited Liability Partnership
		☐ Trust

If Incorporated, Date Incorporated	**Attach a copy of the articles of incorporation, or if a foreign corporation, attach evidence of authority to do business in Wisconsin.**

C. INTERESTED PARTIES

List all names, principal business addresses and the percentage of ownership interest of all officers, directors, stockholders owning 5% or more of stock, members, partners, and all other persons having authority or responsibility for the operation of the organization. For non-profit organizations or governmental organizations, list the names and principal business address of all officers, directors and board members. Attach additional pages if necessary.

Name

Street

City	State	Zip Code	Ownership Percentage

Name

Street

City	State	Zip Code	Ownership Percentage

Name

Address

City	State	Zip Code	Ownership Percentage

INTERESTED PARTIES (continued)

Name			
Address			
City	State	Zip Code	Ownership Percentage
Name			
Street			
City	State	Zip Code	Ownership Percentage

D. List the other types of providers owned by the applicant / licensee.
If more than two, check here ☐ and attach additional pages.

Name – Provider		
City	State	Zip Code
Relationship Type (nursing home, home health agency, community based residential facility, hospital)		
Name – Provider		
City	State	Zip Code
Relationship Type (nursing home, home health agency, community based residential facility, hospital)		

E. SUBSIDIARY / PARENT INFORMATION

1. Is the applicant a subsidiary company, either wholly or partially owned by another organization or business?

☐ Yes ☐ No

If Yes, provide the following information:

Legal Business Name – Parent Company

DBA (Doing Business As)

Type of Ownership

Address

City	State	Zip Code

Contact Person	Telephone Number

2. Is the applicant affiliated with any subsidiaries in the health care field in this state or any other state?

☐ Yes ☐ No

If Yes, provide one of the following:

- Names and addresses of all subsidiaries owned by the parent company, in this state or any other state, (relationship type: nursing homes, home health agencies, hospices, hospitals, rehabilitation facilities, etc.)
- Organizational chart exhibiting the legal business names and, if applicable, the DBA name of all the subsidiaries currently owned by the parent company in the health care field in this state or any other state, (relationship type: nursing homes, home health agencies, hospices, hospitals, rehabilitation facilities, etc.)
- Complete annual report to shareholders.

Is the applicant under the control of a chain organization? ☐ Yes ☐ No

Chain organization is defined as multiple providers, and / or suppliers owned, leased, or through any other devises, controlled by a single business entity (defined as chain home office). Each entity in the chain may have a different owner but the "home office" maintains uniform procedures in each facility for handling utilization review, reimbursement, handling admissions, also maintains and controls centrally, provider / suppliers cost reports, etc.

In addition, a chain facility would not necessarily be a subsidiary of the parent corporation but the chain facility or facilities could be owned by different subsidiaries of the same corporate parent.

Name – Chain Organization

G. FIT AND QUALIFIED

The following information will be used to determine if the applicant meets the fit and qualified requirements under Chapter 50, Wis. Stats.:

1. Has the applicant been affiliated in the past five years with a hospice (HSP), a home health agency (HHA), a residential care facility, e.g., Community Based Residential Facility (CBRF), Adult Family Home (AFH), or a health care facility (HCF), e.g., hospital, nursing home or facility for the developmentally disabled in the State of Wisconsin or in any other state.

   ☐ Yes ☐ No
   IF THE ANSWER IS YES, complete all information in the section below. Use the facility abbreviations (in parenthesis) from above to identify the type of facility.

   IF THE ANSWER IS NO, complete Section G, questions 4 –12.

Facility Name and Address	City and State	Type of Health Care Provider	Owner / Operator / Mgr. Vendor / Provider No.	Dates of Affiliation

2. Has any adverse action initiated by any state licensing agency resulted in the denial (D), suspension (S), or revocation (R) of a license?

   ☐ Yes ☐ No
   If Yes, please complete the following table. Use abbreviations to describe the type of adverse action and refer to III.G.1. for abbreviations for type of health care provider.

Facility Name and Address	City and State	Type of Health Care Provider	Type of Adverse Action	Eff. Dates of Adverse Action

3. Has any adverse action initiated by a state or federal agency based on non compliance resulted in civil money penalties (CMP), termination of provider agreement (TPA), suspension of payments (SOP), or the appointment of temporary management of the facility (TMF)?

☐ Yes ☐ No
If Yes, please complete the following table. Use abbreviations to describe the type of adverse action and refer to III.G.1. for abbreviations for type of health care provider.

Facility Name and Address	Location of State	Federal or State	Type of Health Care Provider	Type of Adverse Action	Effective Dates of Adverse Action

4. Has the applicant ever had a denial, suspension, enjoining or revocation of a health care provider license, in this state or any other state, as defined in s. 146.81 Wis. Stats., or any conviction for providing health care without a license?

☐ Yes ☐ No
If Yes, explain.

5. Has the applicant ever been convicted of a crime involving neglect or abuse of patients, or involved in assaultive behavior, wanton disregard for the health and safety of others, or any act of elder abuse under s. 46.90, Wis. Stats.

☐ Yes ☐ No
If Yes, explain.

6. Has the applicant ever been convicted of a crime related to the delivery of health care services or items?

☐ Yes ☐ No
If Yes, explain.

7. Has the applicant ever been convicted of a crime involving controlled substances under Ch. 161, Wis. Stats.?

☐ Yes ☐ No
If Yes, explain.

8. Has the applicant had any prior financial failure that resulted in bankruptcy or in the closing of a hospice, home health agency or an inpatient health care facility, e.g., nursing home or hospital, or the relocation of its patients?

☐ Yes ☐ No
If Yes, explain.

9. Has the applicant / licensee been adjudicated bankrupt?

☐ Yes ☐ No
If Yes, explain on a separate page. Provide the dates, court and disposition of each action.

10. Are there any unsatisfied judgements against the applicant / licensee?

☐ Yes ☐ No
If Yes, explain on a separate page. Provide the names and addresses of creditors, amounts and the reasons for non-payment.

11. Does the applicant / licensee owe any debts that are 90 days past due?

☐ Yes ☐ No
If Yes, explain on a separate page. Provide the names and addresses of creditors, amounts and reasons for non-payment.

12. Does the applicant / licensee plan to provide care to patients who are unable to pay for service?

☐ Yes ☐ No

13. HOME HEALTH (Complete for HOME HEALTH AGENCY application only.)
Attach proof of sufficient resources as may be necessary to operate the agency for at least 90 days. Proof of sufficient financial resources should include income / expense statements.

14. FINANCIAL REFERENCES
This question is to be completed by the APPLICANT. Do not include relatives. Include at least one bank. Attach additional pages if necessary.

Name		Telephone Number
Address		
City	State	Zip Code
Name		Telephone Number
Address		
City	State	Zip Code

IV. MANAGEMENT COMPANY

A. Is the operation of the facility under a management contract?

☐ Yes ☐ No

If Yes, provide the following information regarding any management company retained to operate this facility or program.

Type of Management Company ☐ Corporation ☐ Partnership ☐ Individual ☐ Government		
Name - Management Company		
Name - Contact Person		Telephone Number
Address		
City	State	Zip Code

B. Identify officers, directors, trustees or supervisors of the management company. Attach additional pages if necessary.

Name	Title
Address	
City	State	Zip Code
Name	Title
Address	
City	State	Zip Code

C. Identify other facilities the management company has owned, operated or managed in the last 5 years. Attach additional pages if necessary.

Name		
Address		
City	State	Zip Code
Dates of Involvement		

Name		
Address		
City	State	Zip Code
Dates of Involvement		

Name		
Address		
City	State	Zip Code
Dates of Involvement		

D. While managing any of the above facilities identified in item C.:

1. Has any adverse action initiated by any state licensing agency resulted in the denial (D), suspension (S), or revocation (R) of a license?

☐ Yes ☐ No

If Yes, please complete the following table. Use abbreviations to describe the type of adverse action and refer to III.G.1. for abbreviations for type of health care provider.

Facility Name and Address	City and State	Type of Health Care Provider	Type of Adverse Action	Effective Dates of Adverse Action

2. Has any adverse action been initiated by a state or federal agency based on non-compliance resulted in civil money penalties (CMP), termination of provider agreement (TPA), suspension of payments (SOP), or the appointment of temporary management of the facility (TMF)?

   ☐ Yes ☐ No
   If Yes, please complete the following table. Use abbreviations to describe the type of adverse action and refer to III.G.1. for abbreviations for type of health care provider.

Facility Name and Address	City and State	Type of Health Care Provider	Type of Adverse Action	Effective Dates of Adverse Action

E. Attach a copy of the signed contract with the management company.

V. CONTACT PERSON

Identify the person responsible for completing this application and who can be contacted if we have questions.

Name	Title	
Telephone Number	Fax Number	Date Application Completed

VI. DESIGNEE

Person authorized to accept personal service and receive registered and certified mail.

Is the administrator also the Designee? ☐ Yes ☐ No If No, provide the following information.

Name – Designee	Title

I understand, under penalty of law that the information provided above is truthful and accurate to the best of my knowledge and that knowingly providing false information or omitting information may result in a fine of up to $10,000 or imprisonment not to exceed 6 years, or both (946.32 Wis. Stats.).

SIGNATURE IN FULL – Applicant (Potential Licensee)	Print Applicant's Name	
Title – Applicant		Date Signed

NOTE: The Management Company cannot attest to or sign on behalf of the applicant (potential licensee).

RETURN THE COMPLETED APPLICATION TO:
Bureau of Quality Assurance
Provider Regulation and Quality Improvement Section
PO Box 2969
Madison WI 53701-2969